NEW PATIENT REGISTRATION FORM – ADULT

SECTION A – PERSONAL DETAILS

Title ☐ **Family name** ☐ **First name** ☐ **Middle name** ☐ **Preferred name** ☐

D.O.B ☐ **Birth Sex** ☐ Female ☐ Male ☐ Other ☐ Unknown

Gender Identity ☐ Female ☐ Male ☐ Non-binary ☐ Gender Diverse ☐ Transgender ☐ Other

Pronouns ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs

Ethnicity

☐ Australian, non-indigenous ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander

Other cultural background (e.g., Mediterranean, Asian, African)

Country of Birth

Is English your first language? ☐ **Yes** ☐ **No**

Do you require an interpreter? ☐ Yes ☐ No

Please specify language

Home address **Postcode**

Postal address **Postcode**

Home phone **Mobile phone** **Work phone**

Email

Medicare card number **Reference number** **Expiry date**

Pensioner concession card **Expiry date**

Health Care card **Expiry date**

Veteran's Affairs card **Type** **Gold | White**

Next of kin **Relationship**
Phone

Emergency contact **Relationship**
Phone

Your occupation

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SECTION B – CONSENT

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email, telephone, or SMS for procedures such as vaccinations, cervical screening tests (Pap test) and other health reviews.

I consent to receiving appointment reminders via SMS	☐ **Yes**	☐ **No**
I consent to receiving clinical reminders via SMS	☐ **Yes**	☐ **No**
I consent to being contacted with clinical communication	☐ **Yes**	☐ **No**
I consent to receiving health awareness information	☐ **Yes**	☐ **No**

Are we able to leave a confidential message for you regarding results, recall, or confirming/changing appointments? (please circle your preference)

Mobile Yes|No **Home** Yes|No **Work** Yes|No

I authorise the following person to take messages regarding a recall, reminder or change of appointment on my behalf:

Name ______ **Relationship** ______

Phone ______

☐ **I have been given a copy of 'Westside Medical Centre Practice Information' sheet (take time to read)**

☐ **I understand that Westside Medical Centre is NOT a bulk-billing practice.**
Payment is required on the day of consult. If you hold a current Pension Card, you will be bulk-billed.

Privacy

It is always the policy of this practice to maintain the security of personal health information and to ensure that this information is only available to authorised members of staff. Patient information may have to be disclosed to other doctors, nurses and medical technicians so that proper health care is not compromised. You can assist in maintaining the accuracy of your information by advising the practice of any changes to your personal contact details.

Is there a Guardianship Order in place for this patient? ☐ **Yes** ☐ **No**

Guardian's name ______

Guardian's phone number ______

Please supply a copy of the Guardianship Order

I hereby declare that the information provided is true and correct.

Signature of patient or guardian ______ **Date** ______

Print name ______

THANK YOU